WHAT SERVICES ARE REIMBURSABLE?

- Medical Nutrition Therapy (MNT)
- Diabetes Self-Management Education (DSME)
WHO CAN BILL FOR THESE SERVICES?

- **MNT-** Registered Dietitians or nutrition professional
  - BS degree from accredited school with 900 hours supervised experience
  - Licensed or certified
  - Billing allowed in hospital outpatient, nursing home, ESRD facility, FQHC, clinic, practice, home health. NOT allowed in hospital inpatient, rural health clinic, skilled nursing home

- **DSME-** Registered Dietitians or Advanced Practice Nurses or through the ADA Programs
  - NPI
MEDICAL NUTRITION THERAPY

- Individualized, detailed and focused nutrition therapy.
- Personalized meal plan and exercise plans.
- Long term follow-up in patients life with extensive monitoring of labs, outcomes, behavior change and meal plan.
MEDICAL CONDITIONS

- Diabetes- T1, T2, GDM
- Non-Dialysis Renal Disease
- Successful Kidney Transplant
DIABETES SELF-MANAGEMENT EDUCATION

- General and basic training in 7 key behaviors in primarily group format.
- Increases patients knowledge of why and skill in how to change behaviors.
- Shorter-term follow-up with limited monitoring of labs, outcomes, etc.
MEDICAL CONDITIONS

- Diabetes, T1, T2, GDM (some plans may cover prediabetes)
QUALITY STANDARDS

- Must use nationally recognized protocols
- Referral must be sent
Diagnoses must be documented

- In medical record maintained by educator/RD and in medical record maintained by provider
- On referral
- On claims

Diagnosis can be selected by authorized professionals only to include physicians, qualified NPPS and licensed medical record coders.
MNT VISIT LIMITS BY CMS

- First calendar year - 3 hours
- CMS coverage of extra hours for change in diagnosis or management plan
- Follow Up years - 2 hours annually
DSME VISIT LIMITS BY CMS

- 10 hours total
  - 1 hour individual
  - 9 hours group
Medicare covers MNT and DSMT but NOT on same day!

**MNT: First Calendar Year, 3 Hrs**
- Individual or group. *Individualized*
- Assessment, nutrition dx, intervention (incl. meal plan) and monitoring & evaluation of outcomes.

**MEDICAL CONDITIONS**
- Diabetes: Type 1, Type 2, GDM, Non-Dialysis Renal Disease, and
- for period of 36 months after successful kidney transplant.

**DSMT: 12 Consecutive Months, 10 Hrs**

**MEDICAL CONDITIONS**
- Nutrition is 1 of 10 topics presented as overview of basic meal planning for BG control (*not* individualized for pt).

*9 hrs of 10 to be group; 1 may be individual. 10 hrs may be individual if provider's documentation of special needs is in DSMT provider's pt chart or no program scheduled in 2 months of referral date.*
CPT CODES

- **97802** - Individual Visit, new patient (Initial)
  - 1 unit = 15 minutes

- **97803** - Individual Visit, follow-up
  - 1 unit = 15 minutes

- **97804** - Group Visit
  - 1 unit = 30 minutes
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MEDICARE MNT RATES

- 97802, per 15 minute unit
  - Non-Facility: $35.04
  - Facility: $32.89

- 97803, per 15 minute unit
  - Non-Facility: $30.03
  - Facility: $27.53

- 97804, per 30 minute unit
  - Non-Facility: $16.09
  - Facility: $15.37
MEDICARE DSME RATES

- G0108, per 30 minute unit
  - $53.27
- G0109, per 15 minute unit
  - $14.30
MNT CLAIM FORM EXAMPLES

**MEDICARE**
- **Hospital OP:**
  - If Hospital is Provider:
  - CMS 1450 = UB04 claim^ or HIPAA 837 Institu ECF*
  - To Part A Intermediary, being replaced by Medicare Administrative Contractors

**PRIVATE PAYER**
- **Hospital OP:**
  - If Hospital is Provider:
  - CMS 1450 = UB04 claim^ or HIPAA 837 Institu ECF*
  - To Private Insurance

- **Private Practice:**
  - RD is provider:
  - CMS 1500 claim or HIPAA 837 Prof ECF**
  - To Part B Carrier, being replaced by Medicare Administrative Contractors..."MACs"

- **Private Practice:**
  - RD is provider:
  - CMS 1500 claim or HIPAA 837 Prof ECF**
  - To Private Insurance
**REJECTED CLAIM**

Medicare returns as unprocessable. Medicare cannot make payment decision until receipt of corrected, re-submitted claim.

- **INCOMPLETE Claim:** Required info is missing or incomplete (e.g., no NPI #).

- **INVALID Claim:** Info is illogical or incorrect (e.g., wrong NPI #, hysterectomy billed for male pt, etc.)

**DENIED CLAIM**

Medicare made determination that coverage requirements not met; example: service is not medically necessary.

To pursue payment, provider can go through Medicare's appeals process.
ADVANCED BENEFICIARY NOTICE (ABN)

- ABN can be used for cases where Medicare payment is expected to be denied
  - Notifies beneficiary prior to service
  - Beneficiary will be responsible for payment if denied
THANK YOU!